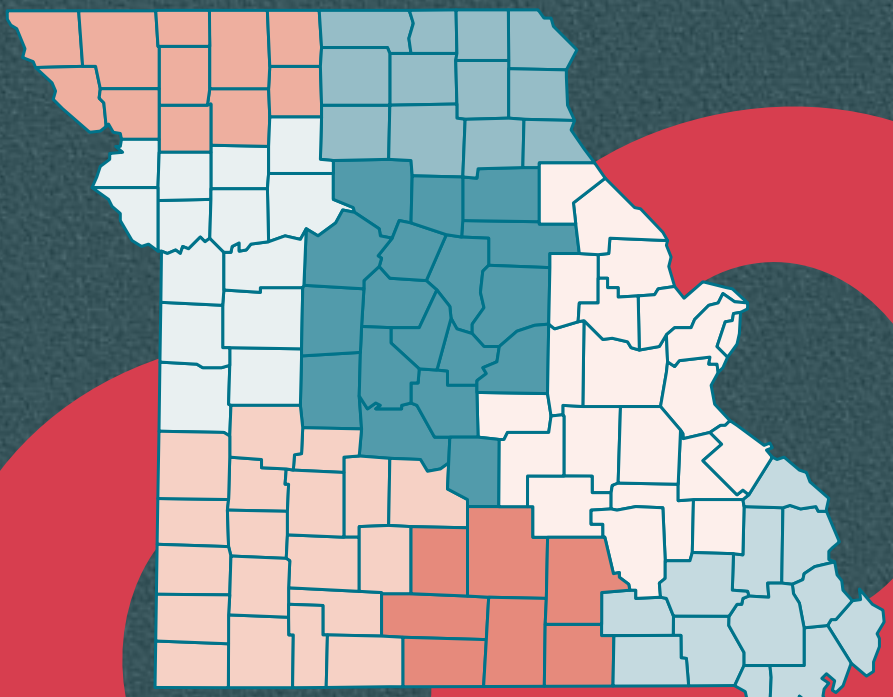
Show me... Buyer's Guide:

MEDICARE MANAGED CARE PLANS



Missouri Department of HEALTH

Contents

The Missouri Department of Health has attempted to publish accurate information based upon common definitions. Managed care plans were given an opportunity to review and correct the data presented. Other corrections or suggestions should be forwarded to the Center for Health Information Management and Epidemiology, Missouri Department of Health, PO Box 570, Jefferson City, MO 65102. Our telephone number is (573) 751-6279. Additional copies of this report may be purchased for $3 each. A companion technical report, containing the data and statistical formulas used, is also available for $10.

A Letter from the Director,

Missouri Department of Health

Dear Missourians:

It is my pleasure to share with you information regarding managed care plans provided by Missouri Medicare managed care providers. The Missouri Department of Health has worked hard to gather comparative information regarding managed care services and present it in a timely and understandable manner. This document is meant to help educate consumers and provide information that will better enable senior Missourians to make informed decisions regarding their health care.

The ***Consumer's Guide: Medicare Managed Care Plans*** provides information that will enable you to compare managed care plans. In partnership with your physician, you now have information with which to make informed decisions about your health care. I encourage you to take the time to use this valuable resource to its full advantage.

Very truly yours,

Maureen E. Dempsey

How To Use This Guide

Consumers have a right to know as much as possible about the services dispensed by health care providers and the outcomes of care. As part of its mission to protect and promote the health of Missourians, the Department of Health (DOH) is pleased to issue this Show me Consumer's Guide to Medicare Managed Care Plans.

The Guide's primary objective is to assist senior health care consumers in making informed choices about managed care options through reports on the quality of care, access to care and member satisfaction. First, however, be sure to review basic Medicare concepts in the literature sent to you by the Medicare administration.

As more senior Missourians enroll in managed care plans, it is important that they have the most reliable information currently available on managed care plans operating in our state. If you are already enrolled in managed care, this guide can help you evaluate the performance of your plan compared with other plans. If you need to make a choice between managed care plans, it can help you compare plans available in your area.

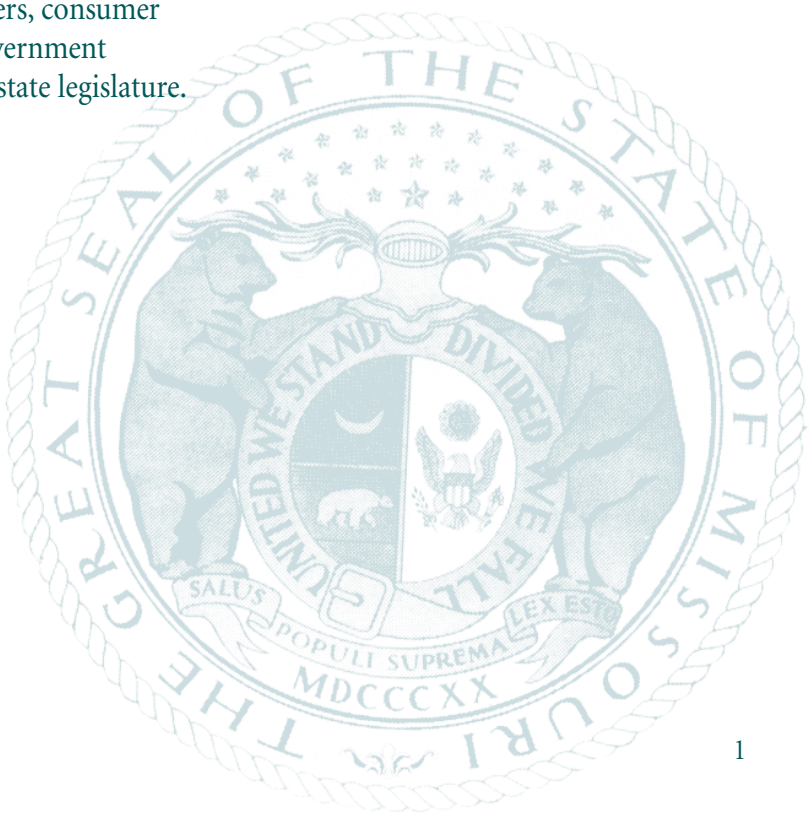
This consumer guide does not provide a simple overall ranking of the health plans. Rather, it identifies several criteria by which Missourians can judge their managed care plan options so they can make the best choice for themselves. Also, find out from family, friends and your doctor about their experiences with the plans you are considering.

In this report we use nationally accepted indicators, surveys and methods, with technical guidance from the National Committee for Quality Assurance (NCQA) and the entities responsible for the Health Plan and Employer Data and Information Set (HEDIS®).* Selection of the HEDIS® indicators and other data presented in this guide is reviewed annually by the Department's Managed Care Advisory Committee. This commitee includes representation from the managed care plans, health care providers, consumer groups, related government programs and the state legislature.

- Read Medicare literature
- Identify plan options
- Review quality indicators
- Ask questions
- Evaluate plans

Only managed care plans that were in operation or that filed performance and satisfaction data for the full reporting year are included in this guide. New plans can be identified by contacting the Community Leaders Assisting the Insured of Missouri (CLAIM) phone number found on page 16.

With better information, consumers can become both more responsible for their own care and also better partners with their health care providers.



* HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Managed Care for Medicare

A Medicare Managed Care Plan is a Medicare approved network of doctors, hospitals, and other health care providers which agrees to give care in return for a set monthly payment from Medicare. A managed care plan may be any of the following:

- Health Maintenance Organization (HMO)
- Provider Sponsored Organization (PSO)
- Preferred Provider Organization (PPO)
- Health Maintenance Organization with a Point of Service Option (POS)

How Does Managed Care Work?

- In most managed care plans, you can only go to certain doctors and hospitals who have agreed to treat members of the plan. Often, you can only see a specialist (like a cardiologist) when you get a referral, which means your plan doctor says it is O.K. to go.
- You can often get extra benefits, like limited outpatient prescription drugs.
- Some managed care plans offer a Point-of-Service option which allows you to go to other doctors and hospitals who are not on the plan's list. This option generally costs you more, but gives you more choice.
- You must continue to pay the monthly Part B premium.
- Some plans charge an additional monthly premium.
- Most plans charge you a set amount (copayment), like $5 or $10 every time you see your doctor.
- You must live in the service area of the plan (the area in which the plan accepts members and where you get services from the plan). Care outside of the United States is usually not covered.

What We Mean When We Say . . .

Terms and their definitions are provided to help consumers understand concepts used in this guide.

Primary Care Provider (PCP)

A primary care provider offers basic services or "first line" care. Usually a physician or nurse practitioner is responsible for well-person care and preventive care to plan members. While the PCP may be the only provider members need to visit for this care, PCPs also coordinate referrals to specialists. Specialists have specific training to treat health care needs like major surgery or complicated cardiac care.

Performance Indicator

Each performance indicator describes a measurable aspect of health care delivery that can be compared with clinically valid criteria to see if a plan meets national quality standards. Collectively, they provide an idea of the quality and appropriateness of care delivered.

HEDIS®

Health Plan Employer Data and Information Set (HEDIS®) is a core set of performance measures developed to assist in understanding value and accountability from a health plan.

Member Satisfaction Indicator

Satisfaction is an important dimension of quality from a member's perspective. The patient's experience with the health care professional, the clinic staff, and the plan's administrative staff and policies can enhance or diminish the medical treatment received.

Quality

Quality for a managed care plan is defined by meeting nationally recognized standards of the technical and interpersonal aspects of care. Appropriate services are those provided in the proper setting and a timely manner to the person in need. All indicators should be reviewed prior to enrolling in or switching to a managed care plan.

Accreditation

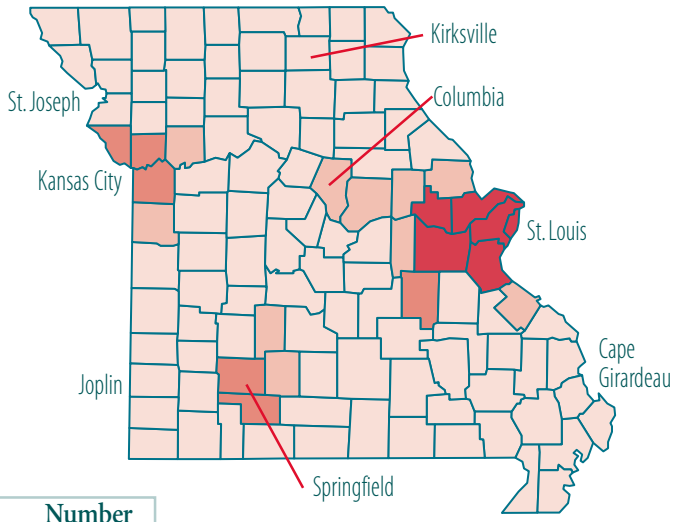
Two national organizations accredit health plans in Missouri: The National Committee for Quality Assurance (NCQA) and American Accreditation Healthcare Commission/Utilization Review Accreditation Commission (URAC). Accreditation is important because it indicates a health plan has met national quality standards.

Current Plan Availablity in Counties

Advantra	Blue-Advantage 65	Blue Horizons	HealthNet Senior Excel	Humana Kansas City	Kaiser Permanente	Medicare Complete UHC	St. John's Premier Plus	Total Health Care 65
Boone	Cass	St. Charles	Cass	Cass	Cass	Franklin	Christian	Cass
Callaway	Clay	St. Louis City	Clay	Clay	Clay	Jefferson	Dallas	Clay
Crawford	Jackson	St. Louis	Jackson	Jackson	Jackson	St. Charles	Greene	Jackson
Franklin	Platte		Platte	Platte	Platte	St. Louis City	Laclede	Platte
Jefferson			Ray		Ray	St. Louis	Webster	
Lincoln						Warren		
St. Charles								
St. Louis City								
St. Louis								
Warren								

Percent of County Enrolled in Medicare Managed Care (1998)

This map shows the percent of each Missouri county's population enrolled in a Medicare managed care plan.[1] There are four different shadings representing percentage increments of enrollment. Most counties do not have Medicare managed care coverage; only 22 counties had Medicare managed care enrollment in 1998.



Shade	Enrollment	Number of Counties
	none	93
	1 - 9.9%	10
	10 - 19.9%	6
	20 - 34.9%	6

[1]Population figures are U.S. Census estimates as of July1, 1998 for 114 Missouri Counties and St. Louis City. Plan enrollment data for Medicare products available as of December 31,1998, excluding self insured packages, were obtained from the Department of Insurance. For those plans not reporting, 1997 enrollments were used. Plan availability is subject to change.

You can get an up-to-date list of the Medicare managed care plans available in your area:

- By calling:
  1-800-MEDICARE
  (1-800-633-4227).
  For the hearing and speech impaired:
  TTY/TDD: 1-877-486-2048
- From the internet at:
  www.medicare.gov.
  Your local library or senior center may be able to help you find this information on their computers.
- By calling the Community Leaders Assisting the Insured of Missouri (CLAIM) program.
  The number for CLAIM is:
  1-800-390-3330.

Medicare Performance Indicators

These indicators are explained in more detail on page 6.

Remember—
No one indicator should be viewed as the sole measure of a health plan's performance

	Breast Cancer Screening	Diabetic Eye Exam	Mental Health Hospitalization Follow-up
Advantra	●	○	●
Blue-Advantage 65	○	○	N/A
Blue Horizons	○	◒	N/A
HealthNet Senior Excel	●	●	N/A
Humana Kansas City	◒	●	◒
Kaiser Permanente	◒	●	N/A
Medicare Complete	◒	○	◒
St. John's Premier Plus	N/A	◒	N/A
Total Health Care 65	◒	○	N/A
Statewide Managed Care Averages	**72%**	**49%**	**46%**
National Managed Care Medians*	**74%**	**54%**	**56%**

Performance Level

- ● — High Performance
- ◒ — Average Performance
- ○ — Low Performance
- N/A — Results not reported due to small numbers
- NR — Plan did not report data or data was biased

Breast Cancer Screening
Percent of women (52-69) who had a mammogram in the past 2 years.

Diabetic Eye Exam
Percent of diabetics having an eye examination in the past year.

Mental Health Hospitalization Follow-up
Percent of patients receiving follow-up after discharge for mental health hospitalizations.

*National averages are unavailable for Medicare managed care. The medians here represent the midpoint in a ranking of the rates, ordered from high to low. Medians are often used as an alternative to an average.

Explanation of the Summary Scores for Performance and Member Satisfaction Indicators:

Plans were required to submit independently audited performance data. The performance and satisfaction indicator rates were compared with the statewide rates of the managed care plans.

Based on the results of a statistical "test of significance," High, Average and Low scores were assigned to each rate. Such a test is used to determine whether the difference seen between a plan's rate and the state average rate are due simply to chance or represent a meaningful difference. Thus, scores of "High" and "Low" only signify a plan's performance relative to other plans and not to some standard of health care functioning. The actual plan rates and methods used to test for statistical significance are available in the Managed Care Technical Report from the Department of Health.

Member Satisfaction Indicators

These indicators are explained in more detail on page 6.

	Getting Needed Care	Ease of Getting Referrals	Getting Care Quickly	How Well Doctors Communicate	Overall Rating of Care Received	Overall Rating of Health Plan
Advantra	◓	◓	◓	◓	◓	●
Blue-Advantage 65	◓	◓	◓	◓	◓	○
Blue Horizons	◓	◓	◓	◓	◓	○
HealthNet Senior Excel	●	◓	●	◓	◓	●
Humana Kansas City	◓	◓	◓	◓	◓	◓
Kaiser Permanente	○	◓	◓	◓	○	○
Medicare Complete	◓	◓	◓	◓	◓	◓
St. John's Premier Plus	NR	NR	NR	NR	NR	NR
Total Health Care 65	◓	●	◓	◓	●	●
Statewide Managed Care Averages	**87%**	**86%**	**90%**	**94%**	**86%**	**82%**
National Managed Care Averages	**85%**	**84%**	**89%**	**94%**	**87%**	**82%**

Getting Needed Care

No problem getting good doctors and nurses, referrals, and neccessary care without delays. Managed care does not mean reducing quality of care. Instead, health plans and physicians work with the patient to avoid unnecessary treatment and costs.

Ease of Getting Referrals

No problem getting a referral to a specialist when needed. When your doctor believes a treatment is needed and right for your condition, you should be able to obtain health plan approval and a timely referral.

Getting Care Quickly

No delay getting advice, routine care, or quick treatment for illness or injury. Managed care plans monitor how doctors deliver health care and assist them in increasing how fast you get seen and treated.

How Well Doctors Communicate

Doctors and nurses listen and explain things clearly, and spend enough time with patients. When health care providers listen and talk things over with patients it is easier to correctly diagnose and treat patients' health needs.

Overall Rating of Care Received

Patients usually distinguish between health care received from providers and services supplied by their health plans. However, the delivery of quality health care is a partnership between the health plans and their network of providers.

Overall Rating of Health Plan

Overall health plan satisfaction includes quality of care as well as non-medical issues such as clinic/hospital locations and availability of transportation, hours of operation and customer service.

Satisfaction Level

- ● — High Performance
- ◓ — Average Performance
- ○ — Low Performance
- NR — Plan did not report data or data was biased

Where We Get Information

Much of the information in this booklet comes from the Health Care Financing Administration (HCFA). HCFA administers Medicare, the nation's largest health insurance program. In Missouri, this agency insures 850,000 lives with about 110,000 enrolled in managed care. HCFA oversees the

- HEDIS® data submitted by Missouri managed care plans and audited by independent, licensed firms.
- Member satisfaction surveys developed by NCQA and conducted by WESTAT, an independent survey firm.
- National managed care averages and medians.

Other information sources include:

- Financial data collected by the Department of Insurance.
- Enrollment and complaint data supplied by the Department of Insurance.
- Disenrollment data submitted by the plans to the Department of Health.

Performance Indicator Definitions

The following definitions have been modified to provide concise yet professionally accurate definitions. For in-depth definitions and data collection methods please refer to the NCQA publication listed at the end of this report.

Breast Cancer Screening

The percentage of women age 52 through 69 years who had a mammogram (an x-ray of the breast) during the reporting year or the preceding year. To identify possible breast cancer at the earliest time, a full breast cancer screen includes mammography and a clinical breast examination (CBE) where the provider checks the breast for suspicious lumps. Women should consult with their physician to determine an appropriate time interval for breast cancer screening, based on family history and other risk factors.

Diabetic Eye Exam

The percent of all known diabetic enrollees who had annual eye examinations by a qualified eye care professional. Early detection and treatment can reduce the numbers of eye problems and preventable blindness associated with diabetes. Annual eye exams are recommended for diabetic patients.

Mental Health Hospitalization Follow-up

The percentage of members hospitalized for selected mental health disorders who were seen on an ambulatory basis, or were in day/night treatment with a mental health provider, within 30 days of discharge.

Satisfaction Indicators Explained

How Satisfied Members Are With Their Managed Care Plan

Detailed below are the member satisfaction questions that make up each of the composite and single question indicators found on page 5. The proportion of members marking the high satisfaction responses bolded in blue determined the reported satisfaction levels.

Getting Needed Care

A big problem, A small problem, **NOT A PROBLEM**

- With the choices your health plan gave you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?
- How much of a problem, if any, was it to get a referral to a specialist that you needed to see? (This question was also used by itself for for the **Ease of Getting Referrals** indicator.)
- How much of a problem, if any, was it to get the care you or a doctor believed necessary?
- How much of a problem, if any, were delays in health care while you waited for approval from your health plan?

Getting Care Quickly

Never, Sometimes, **USUALLY, ALWAYS**

- When you called during regular office hours, how often did you get the help or advice you needed?
- How often did you get an appointment for regular or routine health care as soon as you wanted?
- When you needed care right away for an illness or injury, how often did you get care as soon as you wanted?
- How often did you wait in the doctor's office or clinic [no] more than 15 minutes past your appointment time to see the person you went to see?

How Well Doctors Communicate

Never, Sometimes, **USUALLY, ALWAYS**

- How often did doctors or other health providers listen carefully to you?
- How often did doctors or other health providers explain things in a way you could understand?
- How often did doctors or other health providers show respect for what you had to say?
- How often did doctors or other health providers spend enough time with you?

Overall Rating of Health Care Received

1 2 3 4 5 6 7 **8 9 10**

Worst **BEST**

- How would you rate all the health care you received in the last 6 months from all doctors and other health care providers?

Overall Rating of Health Plan

1 2 3 4 5 6 7 **8 9 10**

Worst **BEST**

- How would you rate all of your experience with your Medicare health plan?

Changes in Quality Measures 1997-98

Looking at the quality of care that a managed care plan provides in certain areas is valuable to members and those deciding whether to join a particular plan. However, it is also instructive to compare plans' performances over time. The following chart shows the pattern of change from 1997 to 1998 in the rates for breast cancer screening and diabetic eye exams for each of the Medicare managed care plans in Missouri. During this period, only two of seven reporting plans increased their rate of breast cancer screening while four of eight plans improved their rate of diabetic eye exams.

Quality of Care Changes 1997-1998 (by plan)

	Breast Cancer Screening			Diabetic Eye Exam		
Medicare Plan Name	1997	1998	**Change**	1997	1998	**Change**
Advantra	86%	80%	**-6%**	54%	44%	**-10%**
Blue-Advantage 65	72%	67%	**-5%**	42%	32%	**-10%**
Blue Horizons	65%	66%	**1%**	40%	49%	**9%**
HealthNet Senior Excel	N/A	79%	**N/A**	53%	65%	**12%**
Humana Kansas City	77%	76%	**-1%**	68%	65%	**-3%**
Kaiser Permanente	76%	73%	**-3%**	57%	85%	**29%**
Medicare Complete	58%	74%	**16%**	29%	43%	**14%**
St. John's Premier Plus	—	N/A	—	—	50%	—
Total Health Care 65	67%	63%	**-4%**	19%	7%	**-12%**
Average:	72%	72%	**0%**	45%	49%	**4%**

Overall Results for Selected Individual Satisfaction Questions

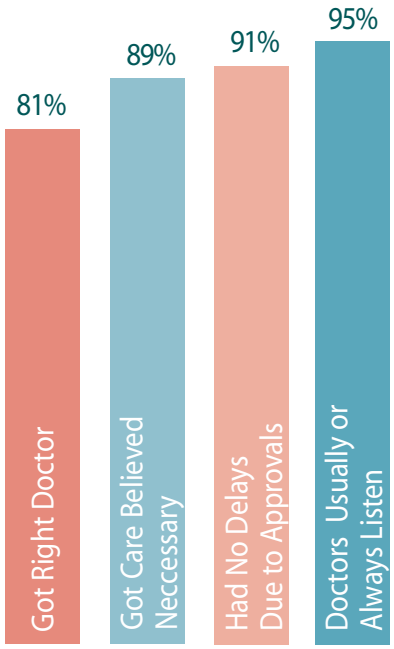
Certain aspects of access to health care are especially prominent in the current discussion and debate about the quality of managed care. The common survey used by Missouri Medicare plans included the following questions on the patient's ability to obtain the "right doctor" and the quality of the patient-doctor interaction.

- Is getting the right doctor not a problem?
- Does the doctor usually or always listen carefully?

Also included in the survey are questions related to the quality of customer service as it relates to plan policies and procedures.

- Was it no problem getting the care the member and his/her ` doctor believed neccessary?
- Was there no problem with delays in health care while waiting for approvals?

The chart to the right displays the average proportion of members reporting "not a problem" or "usually/always" to these questions across all managed care plans.



Access to Care

Screening, Education and Prevention Activities

Plan Name	Physician's Practices Updates	Feedback on Prevention Services	Ed. Materials: At-Risk Patients	Pre/Post Surgery Information	Reminder Calls / Letters: Well Woman Mammogram	Well Woman Check	Immunizations
Advantra	○	○	●	○	●	●	●
Blue-Advantage 65	●	●	●	●	●	●	●
Blue Horizons	●	○	●	○	●	●	●
HealthNet Senior Excel	○	○	●	○	●	○	●
Humana Kansas City	●	○	●	●	●	●	●
Kaiser Permanente	●	●	●	●	●	●	●
Medicare Complete	●	●	●	●	●	○	●
St. John's Premier Plus	●	○	●	○	○	○	○
Total Health Care 65	●	●	●	●	●	●	●

Physician Practices Updates

Did the managed care plan conduct activities for your providers to improve their knowledge on current clinical practice?

Feedback on Prevention Services

Did you provide feedback to your providers on the preventive services in their practices, including comparative benchmark information?

Though these benefits are not directly visible to plan members, practice updates and feedback can significantly improve the quality of the care delivered by providers.

Educational and Prevention Materials for At-Risk Patients

Did your manged care plan directly provide specific educational materials such as health promotion, disease prevention, and wellness information to persons with high risk conditions?

Patient teaching should include written and visual educational materials to prevent the small health problems that can rapidly become serious for people with high risk conditions.

Pre-/Post-Surgical Information

Did your manged care plan directly provide pre- and post-surgical information via general educational materials to all members or specific information targeted to patients with high risk conditions?

For best surgical and healing results, these materials should contain specific and detailed written information on

- pre-/post-surgery diets
- both normal and "warning signal" symptoms after surgery
- possible side effects or drug interactions due to prescribed surgery-related medicines, especially pain-killers.

Reminder Calls or Letters

Did your managed care plan send reminder/recall letters or make telephone calls from your plan office to members to ensure usage of the following preventive services: mammogram, well woman checks, immunizations?

Most managed care plans encourage the use of preventive services tailored to the needs of seniors through reminders. This is a valuable benefit for people who may be vulnerable to health problems.

Activities

● — Yes
○ — No

Selected Plan Benefits

Smoking Cessation	Wellness Survey	Chiropractor	Podiatrist	RN Hotline
◒	●	◒	●	●
●	●	●	●	●
○	●	◒	◒	●
○	●	◒	●	●
○	●	◒	◒	●

Benefits Offered

These managed care plans offer the following benefits to enrollees:

- Smoking Cessation Classes or Medication
- Wellness Surveys
- Chiropractic Services
- Podiatric Services
- Nurse Hotline (after hours or urgent care)

The following preventive care services are mandated by Medicare regulations:

- Routine Physical Exams
- Unrestricted Approval for Annual Flu Shot

Benefits

● — Available for all members
◒ — Available for some members[1]
○ — Not available

[1] Contact plan to determine availability

Medicare Preventive Services

The preventive services (services to help you stay healthy) covered by Medicare managed care under Part B eligibility:

- **All beneficiaries.**
  Vaccinations
  Flu shot: Yearly (Oct.-Jan.).
  Pneumococcal Vaccination: One may be all you ever need—ask your doctor.
  Hepatitis B Vaccination: If you are at high risk for hepatitis.
- **All beneficiaries age 50 and older.**
  Colorectal Cancer Screening
  Fecal Occult Blood Test: Once every year.
  Flexible Sigmoidoscopy: Once every four years.
  Colonoscopy: Once every two years if you are high risk for cancer of the colon.
  Barium Enema: Doctor can substitute for sigmoidoscopy or colonoscopy.
- **All female beneficiaries.**
  Pap Smear and Pelvic Examination: (Includes clinical breast exam) Once every three years. Once per year if you are high risk for cancer of the cervix or had an abnormal pap smear in the preceding three years.
- **All female beneficiaries age 40 and older.**
  Screening Mammogram: Once per year.
- **All diabetic beneficiaries (insulin users or non-users)**
  Diabetes monitoring: Includes coverage for glucose monitors, test strips, lancets, and self management.
- **Certain beneficiaries at risk for losing bone mass.**
  Bone Mass Measurement: Varies with health status.

Starting Jan 1, 2000, Medicare coverage for prostate cancer screening includes digital rectal exam and Prostate Specific Antigen(PSA)Test, once per year.

What Have We Learned About Managed Care?

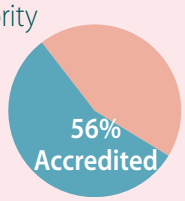
Quality of Care

Managed care members, physicians and plans share a joint responsibility to assure utilization of preventive services such as mammograms and diabetic eye exams. However, an under-utilization of such services exists in managed care. As seen with the preventive health services below, the eligible population for those services show a range of 28% to 54% under-utilization.

Interestingly, though, Medicare plans in Missouri have a higher rate of providing preventive services than commercial plans for Breast Cancer Screening(72% vs. 66%) and Diabetic Eye Exams(49% vs. 32%). Mental Health Hospitalization Follow-ups on the other hand, were lower for Medicare than for commercial plan members(46% vs. 62%). The state averages for both Medicare managed care and commercial plans are displayed below for each of the indicators. Nationwide Medicare results are included for benchmark comparisons.

National Accreditation

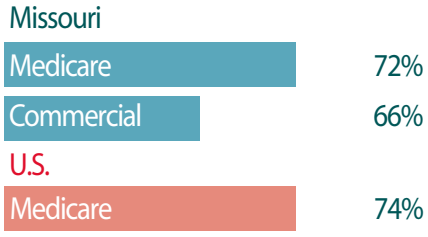
A significant majority of separately reported Missouri plans (5 of 9) were nationally accredited in 1998.



Breast Cancer Screening

Seventy-two percent of women age 52-69 in managed care plans received a mammogram as part of their breast cancer screening in the past two years. Commercial plans averaged only 66%. The national Medicare managed care rate is 74%. The overall state rate for breast cancer screening in this population is virtually unchanged from that reported previously in the 1998 Consumer's Guide.

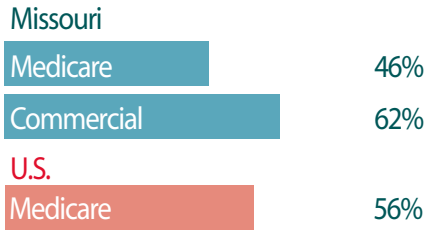
Mammogram



Mental Health Hospitalization Follow-up

For the state's nine reporting Medicare managed care plans, an average of forty-six percent(46%) of patients hospitalized for a mental health condition received a follow-up visit within 30 days. Statewide non-managed care plan follow-up is not available. Most Medicare plans had few members that were eligible for follow-up after mental health hospitalization. Nationally, Medicare managed care plans have a 56% follow-up rate.

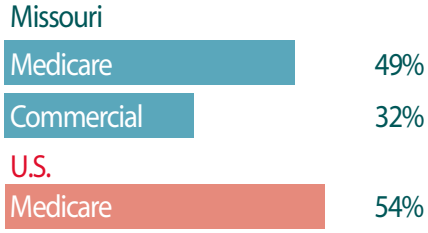
Mental Health Hospitalization Follow-up



Diabetic Eye Care

Only 49% of diabetic persons in Missouri Medicare managed care plans received the recommended annual eye exam. However, the Medicare rate is much higher than that for non-managed care services. The national Medicare median is 54%.

Diabetic Eye Exam

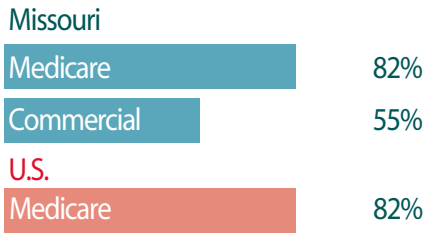


Member Satisfaction

An average of 82% of Missourians enrolled in Medicare managed care reported a high level of satisfaction with their overall health plan experience — the same as the national average. While this is a fairly good rating, it is the lowest of the satisfaction measures reported. Unreported factors such as customer service and claims processing may be responsible for this occurence.

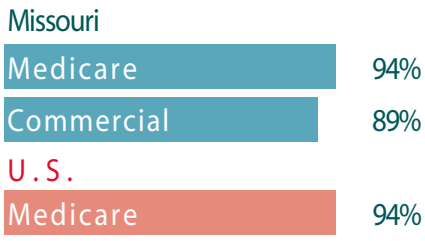
For the more specific satisfaction measures presented below, Missouri and national rates were also similar.

Overall Satisfaction



Both Medicare and commercial managed care enrollees report high levels of satisfaction with their providers of health care. On average, Medicare plans reported that 94% of survey members thought their doctors communicated well. This compares to a commercial plan average of 89% on this same satisfaction indicator.

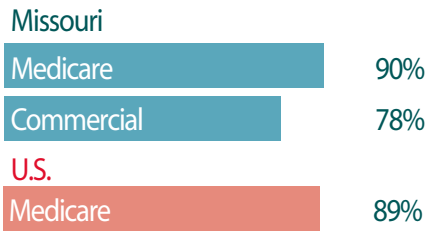
Doctors—Communicate Well



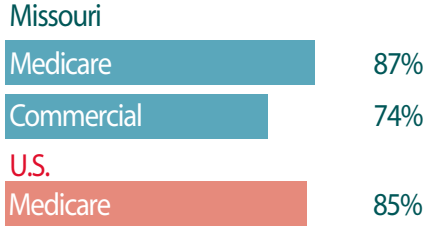
For the overall rating of the health care received, the Medicare plans reported an average of 86% of their members were highly satisfied. This is reflected in the three indicators that measured access to health care. The survey item of getting care quickly resulted in a plan average of 90% of Medicare members satisfied, compared to only 78% for commercial enrollments.

Missouri Medicare benificiaries enrolled in managed care were also more likely than their commercial counterparts to express satisfaction with getting needed care and ease of getting referral.

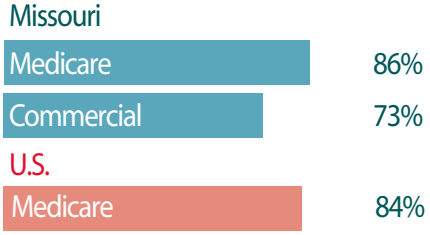
Getting Care Quickly



Getting Needed Care

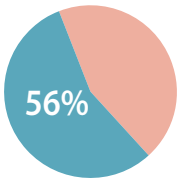


Referral Easy



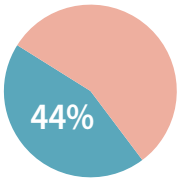
Accessibility

Five of nine managed care plans do provide pre- and post-surgery educational materials.



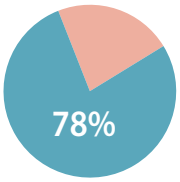
Provide Pre/Post Surgery Educational Materials

Only four out of nine plans pay for smoking cessation programs.



Pay for Smoking Cessation

Seven of nine managed care plans conduct wellness surveys of their members.



Conduct Wellness Surveys

What Do Medicare Managed Care Plans Look Like?

Plan Name	Licensee Name	1998 Medicare Enrollment	% Change in Medicare Enrollment	Statewide Medicare Market Share	1998 Accreditation
Advantra	Group Health Plan Inc Inc.	23,615	35%	21%	NCQA
Blue-Advantage 65	Good Health HMO Inc.	5,352	1%	5%	none
Blue Horizons	HMO Missouri Inc.	5,452	- 5%	5%	NCQA
HealthNet Senior Excel	HealthNet Inc.	7,220	57%	6%	none
Humana Kansas City	Humana Kansas City Inc.	17,563	87%	16%	NCQA
Kaiser Permanente	Kaiser Foundation Health Plan of KC	2,836	7%	2%	NCQA
Medicare Complete	UnitedHealthcare of the Midwest Inc.	43,246	27%	39%	URAC
St. John's Premier Plus	Mercy Health Plans of Missouri Inc.	4,722	108%	4%	none
Total Health Care 65	Blue Cross Blue Shield of Kansas City	—	—	—	none
All Plans		111,502	40%	98%*	

Licensee

Financial and enrollment information in this table (except disenrollment) was supplied by the Dept. of Insurance for each licensed managed care company. Where 1998 data for plans were incomplete or not reported, 1997 data were used.

Use information in this table to assess the financial stability of plans you are considering joining.

Medicare Enrollment

These figures indicate how many Missourians were enrolled in a Medicare managed care plan in 1998. There are strengths and limitations relative to a plan's size. A large plan may be able to spread the risk of high medical expenses from a few very sick members across a more extensive population so they do not adversely impact the plan's overall financial viability. On the other hand, smaller plans may be able to respond more quickly to consumer requests.

Percent Change in Medicare Enrollment

This indicates the percent change in enrollment reported from a plan's annual financial statement between 1998 and 1997. Growth that is too large or fast may forecast delays in customer service and approvals. Shrinking enrollment may indicate problems. However both types of growth may simply be due to coverage area changes.

Statewide Medicare Market Share

This shows the percentage of the State's Medicare managed care plan members who are enrolled with a specific plan. It provides an indication not only of plan size but also of the population size over which plan risk is spread for medical services. Especially when compared to enrollment and other quality or satisfaction indicators, this measure can reflect a plan's success in meeting the varied health care needs of the State's citizens.

Accreditation Status in 1998

Missouri managed care plans could voluntarily seek and qualify for accreditation, indicating that they meet national quality standards from two organizations: National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC).

*Two discontinued plans that are unreported comprised two percent of Missouri's Medicare market share in 1998.

1998 Disenrollment	1997-1998 Complaint Index*	1996-1998 Days in Unpaid Claims Ratio*	1996-1998 Medical Expense Ratio*	1996-1998 Administrative Expense Ratio*
7%	◓	●	90%	●
15%	●	●	90%	●
14%	○	◓	98%	◓
8%	●	○	86%	◓
15%	○	●	84%	●
18%	●	●	98%	●
9%	○	◓	88%	●
7%	◓	◓	96%	◓
15%	—	—	—	—
10%	87	48	91%	17%

Disenrollment

This is the percentage of all managed care plan enrollees who left the plan for any reason including death. This measure serves as an indicator of stability of membership in the health plan. It does not distinguish between members who leave because of dissatisfaction and members who leave for other reasons, so it should not be used as a proxy for dissatisfaction.

Complaint Index

The complaint index compares to the industry average the number of consumer complaints the Missouri Department of Insurance has received in the past two years relative to the amount of business a specific company writes in Missouri. Plans at less than 50% of industry average are shown as high performance; more than 100% of industry average is shown as low performance.

Days in Unpaid Claims

This indicator tells how long it takes plans to pay benefits and other bills. It is important because it tells how long providers have to wait to get paid. High performance is less than 45 days, average performance is 45-59 days, low performance is 60 days or more.

Medical Expense Ratio

This is the percentage of total premiums and related revenues that covers total medical and hospital expenses. A ratio that is too high can mean the plan may not be making sufficient profit to stay in business. Too low a ratio may mean the plan is not spending enough revenues on medical and hospital expenses. A ratio between 85% and 95% should be considered typical, although a plan that is just starting up may have a lower ratio.

Administrative Expenses/Total Revenue

This is the percentage of total income used for administrative overhead. It is an indicator of "efficiency." Plans with administrative expenses less than 15% are shown as high performance. Plans with administrative expenses between 15% and 25% are shown as average and plans with administrative expenses of 25% or more are shown as low performance.

Performance Level

● — High Performance
◓ — Average Performance
○ — Low Performance

*This is a company-wide measure and does not derive solely from the Medicare health plan.

Choosing a Managed Care Plan

If you decide to join a Medicare managed care plan remember — you are still in the Medicare program with all its rights and protections. You continue to get all regular Medicare covered services. However, choosing a managed care plan can be complex and difficult. Follow these helpful steps to make it easier:

- Identify all plans which offer coverage in your area by calling the Community Leaders Assisting the Insured of Missouri(CLAIM) program at 1-800-390-3330 or 1-573-893-7900.
- Review the indicators in this booklet only in combination. No one indicator should be viewed as a sole direct measure of a health plan's performance.
- Come up with your own questions and call your plan choices for answers using the phone numbers in the back. Plans can provide you a member handbook of benefits plus a list of doctors and hospitals in their Medicare network.
- Contact CLAIM for a health plan comparison worksheet and other Medicare information.
- Talk to your doctor, family and friends about their experiences with managed care.
- Use all information to evaluate your managed care options. Make the choice that best suits your need.

Will My Out-of-Pocket Costs Change With Managed Care?

Your costs will depend upon:

- Whether the plan charges a premium in addition to the monthly Part B premium ($45.50 in 2000).
- How much the plan charges per visit, such as a $5 or $10 copayment every time you see your doctor (in place of the 20% coinsurance charged in Original Medicare).
- The type of health care you need and how often you get it.
- How much the plan charges for extra benefits.
- Whether you get health care outside the service area of the plan (except in an emergency).

Sample Questions for Managed Care Plans

In addition to the information provided in this guide, you should also ask the plan the following types of questions:

1. Is my current practitioner a part of the managed care plan's network? Will I be able to see the same primary care doctor all of the time?
2. I am under the care of a specialist — is he or she part of the plan's network? Does the plan require prior authorization for specialty care? Is it possible to receive services from a specialist not affiliated with my managed care plan?
3. What extra preventive services does the plan offer (e.g. physical exams, immunizations)?
4. How and where do I obtain after-hours care?
5. How do I receive care if I am out of town or in another state? What will be the cost of this care?
6. How are complaints or grievances handled?
7. Does the plan offer translation services if needed?
8. What are my premium costs? Co-payments?
9. What specialized hospitals are in the plan's network?
10. Are all outpatient prescription drugs covered?

To Join a Managed Care Plan.

1. Call the plan and request an enrollment form.
2. Fill out the form and mail it to the plan.
3. You will get a letter telling you when your coverage begins.

Note: *During the month of November, Medicare managed care plans (with some exceptions) must accept new members. If you join in November, your coverage begins on January 1.*

Before You Join a Medicare Managed Care Plan, keep in mind that...

- Managed care plans are offered by private companies. Each year they can change the extra benefits they offer and how much they charge. The plans must tell you about these changes in advance.
- When managed care plans sign a contract with Medicare, they agree to stay for at least one calendar year. Each year, they make a business decision to stay with or leave the Medicare program.
- Doctors can join or leave managed care plans at any time.
- Managed care plans may charge an extra monthly premium, in addition to your monthly Part B premium.
- Some managed care companies limit the number of members in their plans. These plans may not accept new members all of the time. A company can tell you if a plan has reached its limit or is still signing up new members.

Can I Keep my Medigap Policy If I Join a Managed Care Plan?

If you join a Medicare managed care plan, you may keep your Medigap policy (but you can't use it unless you return to the Original Medicare Plan). If you drop your Medigap policy, you **may** have the right to get another Medigap policy later if:

- You lose your Medicare managed care plan coverage(through no fault of your own), or
- You join a Medicare managed care plan for the first time, and within one year of joining, you decide you want to leave managed care. If you were new to Medicare when you joined the plan, you may be able to choose any Medigap policy you want. If you already had a Medigap policy before you joined the plan, you may be able to re-enroll in the same policy as before.

Need More Information about Medigap?

Contact the Missouri CLAIM program at:
1-800-390-3330

Know Your Medicare Rights

You have guaranteed Medicare rights even when you are covered under a Medicare managed care plan. These rights protect you when you get health care. They assure you access to needed health care services and they protect you against unethical practices.

As a Medicare beneficiary you have the right to:

- see your primary care provider
- choose a women's health specialist
- receive specialty care that is medically necessary
- receive urgent, after-hours and emergency care
- information about all treatment options available to you
- access to health care providers without unreasonable distances to travel or lengthy delays
- access to specific preventive services at medically appropriate times
- see your medical records
- privacy about your medical condition
- protection from discrimination in marketing and enrollment practices
- know how your Medicare health plan pays its doctors
- information about what is covered and how much you have to pay
- not be charged or billed by network providers for covered services that managed care plans fail to pay
- appeal decisions to deny or limit payment for medical care

For FREE help when your Medicare rights have been violated, call Community Leaders Assisting the Insured of Missouri (CLAIM). The CLAIM number is 1-800-390-3330.

Know Your Responsibilities

Know the rules of your managed care plan before you use medical services.

You have a responsibility to:

- select a regular medical provider
- schedule appointments and keep them, or call to cancel
- read materials given to you and ask questions about anything you do not understand
- make sure that you follow the rules of your managed care plan

References:

Medicare Patient Rights. HCFA Publication No. HCFA-10112

Your Medicare Benefits. HCFA Publication No. HCFA-10116 rev. May1999

Medicare and You 2000. HCFA Publication No. HCFA-10050 rev. Jan. 2000

Understanding Your Medicare Choices. HCFA Publication No. HCFA-10120 rev. June 1999

Healthy People 2000. Department of Health and Human Services Publication No. (PHS) 91-50212.

Missouri Health Maintenance Organization Report 1998. Missouri Department of Insurance Managed Care Section, December, 1999.

National Committee for Quality Assurance. HEDIS® 2.0/1999. Washington DC: NCQA, 1998.

U.S. Preventive Services Task Force. Guide to Clinical Preventive Services, 2nd ed. Baltimore: Williams & Wilkins, 1996.

Telephone Numbers and Websites

Medicare Plan	Customer Service	RN Hotline
Advantra	800-533-0367	314-493-9090
		800-580-9733
Blue-Advantage 65	816-395-3062	816-395-3989
	(TDD)816-842-5607	
Blue Horizons	800-932-4480	888-485-2583
HealthNet Senior Excel	800-804-3246	800-533-0844
Humana Kansas City	800-992-2551	800-622-9529
Kaiser Foundation Health Plan	800-726-5247	913-385-1155
	913-642-2662	
Medicare Complete	800-656-0065	877-365-7949
	314-592-7996	
St. John's Premier Plus	800-481-4466	800-909-8326
	(TDD)800-446-1468	
Total Health Care 65	816-395-2525	816-395-3989
	(TDD)816-842-5607	

Website Pages

The following web pages may be useful:

Missouri Department of Health:
www.health.state.mo.us

Official Medicare -
U.S. Government Site:
www.medicare.gov

HCFA's Medicare Compare:
www.medicare.gov/comparison

National Committee for
Quality Assurance:
www.ncqa.org

American Accreditation Healthcare
Commission/URAC:
www.urac.org

Managed Care Central:
www.familiesusa.org/managedcare

Health and Human Services
U.S.Government:
www.healthfinder.gov

National Health
Information Center
nhic-nt.health.org

American Medical Association:
www.ama-assn.org

American Osteopathic Assosiation:
www.aoa-net.org

Agency for Healthcare Research &
Quality:
www.ahrq.gov

American Association of Health
Plans:
www.aahp.org

State Requirements for Health Plan Disclosures

Required disclosure information can be found in the Revised Statutes of Missouri, Section 354-442 Statutes of Missouri Supplemental 1997.
Visit the website at:
www.moga.state.mo.us/homestat.htm.

Concerns or Complaints?

If you have concerns about your treatment or feel you have been denied health services, you may call your managed care plan. The plan will explain how to file a complaint and advise you of your grievance rights.If you disagree with a plan's position or decision, you can file a complaint with the Missouri Patient Care Review Foundation Beneficiaries Helpline at:
1-800-347-1016

The Department of Health expresses genuine appreciation to the following persons who assisted in making this report possible.

MANAGED CARE PLAN ADVISORY COMMITTEE

Patricia Ahrens, Missouri Nurses Association

Bonnie Bowles, Executive Director, Missouri Association of Osteopathic Physicians & Surgeons

Milisa Suckow, Quality Improvement Director, Community Health Plan

Jackie Meeks, Group Health Plan

Shelley Bowen, Assistant Vice President of Quality Management, Blue Cross and Blue Shield of Kansas City

Myrna M. Bruning, Deputy Director, Program Development/QA, Division of Medical Services

Carl Bynum, DO, MPH, Missouri Association of Osteopathic Physicians & Surgeons

Gordon Butler, American Association of Retired Persons

Henry A. Curran, Assistant Executive Director, Missouri Consolidated Health Care Plan

Marty Exline, Policy Coordinator, MO Assistive Technology Project

Kurt Heumann, Director, Data Analysis & Interpretation, United Healthcare of the Midwest

Deborah Jantsch, MD, Mid-American Coalition on Healthcare

Jacob J. Lippert, DDS, Executive Director, Missouri Dental Association

Robert McCormick, MD, Associate Medical Director/Quality Management, Humana, Inc.

Kay Meyer, RN, MPH, Manager of Corporate Quality Improvement, Alliance Blue Cross/Blue Shield

Becky Miller, Missouri Hospital Association

Louise Probst, Executive Director, Gateway Purchasers of Health

Leah Rubin,Business Manager, Webster Eye Care

Molly White, Health Care Specialist, Department of Insurance

Bruce Vieweg, Deputy Director, OIS, Department of Mental Health

DEPARTMENT OF HEALTH STAFF

Maureen Dempsey, MD, Director, Department of Health

Garland Land, Director, Center for Health Information Management & Epidemiology

Susan Elder, Chief, Bureau of Health Care Performance Monitoring

John H. Song, Research Analyst, Bureau of Health Care Performance Monitoring

Judy Fraas, Research Analyst, Bureau of Health Resources Statistics

Kay Forbis, Clerk Typist, Bureau of Health Resources Statistics

Sheila Ivory, Clerk Typist, Bureau of Health Resources Statistics

Diann Six, Administrative Secretary, Center for Health Information Management & Epidemiology

Missouri Department of
HEALTH

MISSOURI CENTER FOR HEALTH STATISTICS PUBLICATION NO. 21.8